Massachusetts Summary

Background
Since 2001, program integration has been a normative and priority process within the Division of Health Promotion and Disease prevention. Over the years the Chronic Disease Director has led the Division's programs toward integration through coordination and partnership. Program directors and evaluators have met weekly to develop templates for burden of disease documents, statewide plans, and policy initiatives. This collaborative process has led to shared funding resulting in increased capacity to expand program reach.

The aim of the Massachusetts Program Integration Demonstration Project is to *Improve and eliminate disparities in health outcomes for Massachusetts residents across the life span through chronic disease program integration.*

The Integration Demonstration Project is based on three goals:

- **Develop an infrastructure to strengthen the role of Public Health in State Health care Reform**
  The first goal of the Massachusetts Integration Pilot Project is to ensure that the Department of Health (DOH) chronic disease programs are integrated with the statewide health care reform initiatives spearheaded by the Governor, Secretary of Health and Human Services, and the Commissioner. This integration will be reflected in the design and action plans of each chronic disease program as well as the Integration Demonstration Project work plan. The DOH has developed matrices to compare statewide health care reform initiatives with DOH chronic disease program priorities to identify opportunities for integration.
- **Develop internal structure to strengthen the principles and programmatic needs for integration of chronic disease programs**
  The DOH is bridging existing program components to create a culture of integration that promotes resource sharing, collaborative planning, and increased efficiency. Staff from categorical chronic disease programs, along with DOH leadership, works collaboratively to identify opportunities for integration in the areas of administration/operations, surveillance, evaluation, training, health communications, and the development and delivery of interventions.
- **Develop and implement a comprehensive community-based pilot intervention supporting the prevention and improved management of chronic diseases.**
  The Community Intervention includes a focus on both primary prevention and disease management activities. With respect to primary prevention, a Comprehensive Wellness Initiative was launched in January, 2009. In the Summer of 2009, planning will take place across DOH chronic disease programs to: 1) identify priority primary prevention activities from the Wellness Initiative; and 2) determine how to link these prevention activities with health care sites to improve management of chronic disease in high risk communities. A key outcome for the community model will be the linkage between community prevention programs and health care to improve patient self-management.